IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD ARMSTRON – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

June 22, 2007

Phil Herink
Sunhealth Behavioral Health System for Boise
8050 Northview Street
Boise, Idaho 83704

RE: Sunhealth Behavioral Health System for Boise, provider #134009

Dear Mr. Herink:

Based on the Medicare/Licensure survey completed at Sunhealth Behavioral Health System for Boise on June 8, 2007 by our staff, we have determined that Sunhealth Behavioral Health System for Boise is out of compliance with the Medicare Hospital Conditions of Participation on Patients' Rights (42 CFR 482.13) and Medical Staff (42 CFR 482.22). To participate as a provider of services in the Medicare Program, a hospital must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused this condition to be unmet substantially limit the capacity of Sunhealth Behavioral Health System for Boise to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance. Such corrections must be achieved and compliance verified, by this office, before **July 23, 2007. To allow time for a revisit to verify corrections prior to that date, your Credible Allegation must be received in this office no later than July 12, 2007.**

The following is an explanation of a credible allegation:

Credible allegation of compliance. A credible allegation is a statement or documentation:

- Made by a provider/supplier with a history of having maintained a commitment to compliance and taking corrective actions if required.

- That is realistic in terms of the possibility of the corrective actions being accomplished between the exit conference and the date of the allegation, and

- That indicates resolution of the problems.

In order to resolve the deficiencies the facility must submit a letter of credible allegation to the Department, which contains a sufficient amount of information to indicate that a revisit to the facility will find the problem corrected.

As mentioned above, the letter of credible allegation must indicate that the problems have been corrected as of the date the letter is signed. Hence, a plan of correction indicating that the correction(s) will be made in the future would not be acceptable. Please keep in mind that once the Department receives the letter of credible allegation, an unannounced visit could be made at the facility at any time.

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

Also pursuant to the provisions of IDAPA 16.03.14.150.01.g, Sunhealth Behavioral Health System for Boise is being issued a Provisional hospital license. The license is enclosed and is effective June 8, 2007, through October 8, 2007. The conditions of the provisional license are as follows:

1. Post the provisional license.

2. Correct all cited deficiencies and maintain compliance.

Please be aware, that failure to comply with the conditions of the provisional license, may result in further action being taken against the hospital's license.

Be advised, that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit to the State Survey Agency a written request by **July 20, 2007**. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review. Your written request for administrative review should be addressed to:

Randy May, Deputy Administrator
Division of Medicaid -- DHW
P.O. Box 83720
Boise, ID 83720-0036
phone: (208)364-1804
fax: (208)364-1811

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decision to issue the provisional license becomes final. Please note that issues which are not raised at an administrative review may not later be raised at higher level hearings (IDAPA 16.05.03.301).

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208)334-6626.

Sincerely,

SYLVIA CRESWELL, Supervisor
Non-Long Term Care

SC/mlw

Enclosure:

cc: Steve Millward
ec: Debra Ransom, R.N., R.H.I.T., Bureau Chief

SunBridge

SunHealth Behavioral Health System for Boise
8050 Northview St
Boise, ID 83704
208.327.0504
Fax 208.327.0594

July 12, 2007

Ms. Sylvia Creswell
Supervisor/Non-Long Term Care
Idaho Department of Heath & Welfare
Bureau of Facility Standards
3232 Elder Street
Boise, ID 83720-0036

Re: Credible Allegation of Compliance for Sunhealth Behavioral Health System for Boise, Provider #134009

Dear Ms. Creswell;

Pursuant to your letter dated June 22, 2007, I hereby submit the following letter of Credible Allegation of Compliance for the Medicare/Licensure survey completed on June 8, 2007. Submission of this Letter of Credible Allegation does not constitute an admission or agreement of the facts alleged or the conclusions set forth in any subsequent Statement of Deficiencies.

The corrective actions identified below were completed as of the date of this letter of Credible Allegation of Compliance.

The following plan of action outlines immediate interventions employed by the Facility to correct the citations as alleged in the 2567 dated 06/08/2007:

A049

The Hospital has enhanced it's involuntary hold policy (formally Administrative Hold) that identifies documentation and evaluation procedures for staff to follow in the event a patient is a danger to self, others or gravely disabled and it is determined that an involuntary hold is necessary. In addition, a commutability assessment has been developed to evaluate the patient's psychological status and supports the claim of grave disability due to mental illness or imminent danger to self or others.

Evidence supporting the claim grave disability due to mental illness or imminent danger will be faxed to the dully authorized court within 24 hours.

Social Services, Licensed Nurses (RN, LPN) and the facility physicians have been in-serviced on the policy and documentation required for the process. The facility's Director of Social Services will audit patient charts of all involuntary holds to monitor the process to ensure that patient's rights are duly protected. All results will be reported to the facility's Quality Assurance, Medical Staff and Governing Board Committee and action plans developed for any issues noted.

A181

Please refer to Corrective Action provided under A049.

A185

The Hospital has developed a comfort care policy that will direct the staff on how to care for patients with a comfort care order. This policy is flexible enough that patients and/or families through the care plan process can provide input into what areas they would like treated or not. The facility's Licensed Nurses (RN, LPN) have been in-serviced on the policy and documentation required for the successful Implementation of this policy. The facility's DNS or designee will audit patient charts of all comfort care patients to monitor the process and care plan any concerns. All concerns will be addressed immediately. Medical staff is and continues to be accountable for the medical care provided to the patients via the peer review process. All results will be reported to the facility's Quality Assurance committee and action plans developed for any issues noted.

DNS or designee in conjunction with designated medical Staff will concurrently review clinical information to assure treatment is addressed appropriately and timely for identified infections. Variances will be reported to the Quality Assurance and Medical Executive Committees.

The facility's Preparation of Peer review policy has been updated to include a medical peer review. The facility will have 4 charts per quarter per physician including but not limited to medical review and unexpected clinical outcomes, death and family grievances. Results of the peer review will be presented to the Hospitals Medical Executive Committee and the Governing Board.

A204

All Licensed Nursing Staff have been in-serviced on the assessment and documentation of patients who are experiencing acute medical changes of conditions and notification to the attending physician when changes occur, including the facility's "Chest Pain-Angina" policy and the comfort care policy. Change of conditions will be reviewed on a daily basis through internal facility processes. The DNS or designee will audit charts of patients with acute medical changes of condition and look to see if proper assessments, documentation and physician notification occurred. Results will be presented to the facility's Quality Assurance committee and action steps taken for and issues noted.

A205

The Hospital has and continues to have nursing care plans for each patient. The Hospital has developed a comfort care policy that will direct the staff on how to care for these patients placed on comfort care. This policy will allow individualization for patients and families through the care plan process In addition nursing staff will care plan interventions for patients who have intrusive/wandering behaviors. All Licensed Staff (RN, LPN) have been in-serviced on the comfort care policy and the care planning process for interventions for patients with intrusive behaviors. The Director of Nursing or designee will audit patient charts for comfort care and behaviors to assure proper interventions/care plans are in place. Results will be presented to the facility's Quality Assurance committee and action steps taken for and issues noted.

Please accept this letter as our Credible Allegation of compliance. If you should have any questions regarding this letter of Credible Allegation of Compliance, please do not hesitate to contact me at 208-327-0504.

Sincerely,

Philip Herink
CEO

cc: Chuck Bosen
Brent Weil

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

August 15, 2007

Mr. Philip Herink, Administrator
Sunhealth Behavioral Health System for Boise
8050 Northview Street
Boise, Idaho 83704

Provider #134009

Dear Mr. Herink:

On **June 8, 2007**, a Complaint Investigation was conducted at Sunhealth Behavioral Health System. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003056

Allegation #1: The hospital refused to discharge a patient when the patient's family requested that the patient be discharged to her home. The physician refused to discharge the patient to the husband without being granted power of attorney.

Findings: An unannounced visit was made to the hospital on 6/4/07 through 6/8/07. Clinical records, hospital policies, and quality improvement documents were reviewed and staff were interviewed.

The hospital's "Administrative Hold" policy, dated 11/4/04, stated the facility could "hold a patient against their will when the Medical Staff believes the patient may be at high risk for injury to self or others or so severely disabled from mental illness that the patient may be unable to care for self to provide food or shelter...In the event the patient announces a plan or intention to leave the hospital AMA (Against Medical Advice) the physician places the patient on Administrative Hold and initiates petition for a DE (Designated Examiner) to confine patient against their will." The policy did not adequately specify a procedure to evaluate patients for administrative hold nor did it specify a procedure to remove a patient from a hold once it had been implemented.

One patient record documented an 83 year old female who was admitted on 2/13/07 with a diagnosis of vascular dementia with delusions. She was discharged home on 2/25/07. According to her discharge summary, dated 2/26/07, the patient was "very aggressive while she was at the hospital and the patient was very close to the end of her life and was placed on comfort measures." It further stated, the family of the patient had "expressed the desire for the patient to return home and die." The summary stated "they had problem-solved and set up hospice to visit in the home" on 2/25/07. An assessment to determine whether the patient was a danger to self or others or was gravely disabled due to psychiatric illness was not documented.

The patient's "Psychosocial Assessment," completed by the SW and dated 2/16/07, stated the patient's daughter had signed the patient into the hospital and the patient's husband, children and grandchildren all lived locally. Further, the assessment stated the daughter said that the patient wanted to go home and the patient's spouse wanted her to return home also. The assessment goal for hospitalization was to stabilize the patient so she could be discharged to a less restrictive setting. On 2/20/07, nursing notes and LSW progress notes stated the patient refused to eat or drink for the last 4 days and comfort measures were discussed with the family. An order for comfort measures was written by the physician on that day.

A nursing note in this patient's record, dated 2/23/07 at 3:30 PM, stated a meeting had taken place with the patient's husband, son and granddaughter regarding the patient being placed on an administrative hold due to the family wanting to take the patient home. A progress note from the patient's attending physician, dated 2/24/07, stated the family wanted to take the patient home on 2/23/07, "but nobody had power of attorney or guardianship so the patient was placed on a hold." An order by the attending physician, dated 2/23/07 but not timed, placed the patient on an administrative hold. An "Application for Commitment" was filled out but not signed, notarized, or filed with the courts. The commitment application stated the purpose for the hold was because the patient was grabbing at staff and other patients and was moaning out loud. It also stated the patient tried to bite an RN and was "biting hair and clothing."

On 6/6/07 at 8:10 AM, the patient's attending physician was interviewed. He stated, the family of the patient came to the hospital and wanted to take her home. He said he was concerned about the possibility of neglect due to the husband being elderly and frail. The physician stated he placed the patient on administrative hold to sort the situation out. He said the patient's granddaughter was involved with this decision and had agreed to the hold process. This statement was not supported by the granddaughter who was subsequently interviewed. The physician said he dropped the hold on 2/25/07 due to the granddaughter and hospice's involvement. He stated he felt comfortable to discharge the patient at that time. He said that putting the patient on a hold bought the hospital time to get the granddaughter and hospice involved.

Two other records were reviewed of patients who were placed on involuntary holds until family members provided evidence of power of attorney for health care. Neither record documented an evaluation showing the patients to be a danger to themselves or others or were gravely disabled by a psychiatric illness.

Idaho Statutes 66-326 provides that a patient in a hospital may only be held against their will if they are determined to be a danger to themselves or others or are gravely disabled by a psychiatric illness. Such a determination was not documented for the three cases noted above.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited. Deficiencies were cited at 42 CFR Part 482.13 Condition of Participation for Patient Rights.

Allegation #2: Patients often are left unattended and walk into other patients' rooms unsupervised.

Findings: Only one record reviewed documented wandering behavior. A male was admitted to the hospital on 2/1/07. The patient's medical record documented the following intrusive behaviors:

2/2/07 - "intrusive going into other patient's rooms"
2/3/07 - "going into other patient's rooms, inappropriate elimination"
2/5/07 - "intrusive... inappropriately voiding in trash cans"
2/7/07 - "intrusive to pt's rooms, getting in pt's beds empty or not"
2/9/07 - "in & out of pt rooms"

On 6/6/07 at 2:34 PM, a charge RN confirmed that the patient did wander into other patient's rooms. She stated that patients would sometimes wander "quickly in and out" of other patient's rooms. She stated they did not update or change a patient's "Plan of Care" if they had intrusive behaviors.

The acting Director of Nursing Services, on 6/7/07 at 3:50 PM, confirmed that the patient had wandered into other patient's rooms while he was in the hospital. Additionally, she confirmed that the patient's "Plan of Care" did not provide interventions to guide staff on how to prevent his intrusive behaviors.

The acting Director of Nursing Services, on 6/7/07 at 3:50 PM, confirmed that there were times when female patients did complain that male patients were wandering into their rooms. She stated that sometimes male patients did enter the female patients rooms at night but that no one had been harmed. She said that staff put up "Stop" or "Do Not Enter" signs on doors and that staff did 15 minute checks on all patients 24 hours a day. Additionally, she stated they would move a female patient closer to the nurses station if they were frightened.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited. Deficiencies were cited at 42 CFR Part 482.23(b)(4) Nursing Care Plan.

Allegation #3: An identified patient was given intramuscular (IM) injections.

Findings: Eighteen clinical records were reviewed. One patient's record documented an 83 year female was admitted on 2/13/07 with diagnoses of vascular dementia with delusions. She was discharged on 2/25/07. According to her discharge summary, dated 2/26/07, the patient "would not take anything orally." On 2/20/07 (time not noted), the physician discontinued all oral medications and ordered IM medications. Further, the record documented that the patient was at times: very aggressive, delusional, combative, biting, hitting staff and would refuse oral medications resulting in receiving IM medications. A progress note from a Physicians Assistant dated 2/24/07, stated, the patient had a lower lobe pneumonia. The patient's "Nursing Progress Note" dated 2/24/07 at 5:00 PM, stated that the patient's husband and son opted for IM antibiotics to treat the pneumonia and this was ordered by the PA. The patient received IM medications as ordered on 2/16/07, 2/17/07, 2/18/07 (twice), 2/20/07, 2/22/07 and 2/24/07.

Medical records documented other patients had received IM medications as ordered when they were unable to take medications orally. Evidence of the over-medication of patients was not present in the records or observed during the survey. Patients did receive prescribed IM medications. However, the hospital did not act inappropriately by providing medications to patients through IM administration.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: A patient's lips were bruised and cut and her face also had bruises.

Findings: Incident reports from 1/1/07 through 5/31/07 were reviewed. While a small number of bruises were noted, the facility had investigated these incidents and they were explainable. These were bruises on arms and legs. They appeared to be the result of falls or combative behavior. No bruising on patients' faces or other suspicious areas was documented. Photographs of a patient with bruises on her face and lips that were taken following hospitalization were reviewed by surveyors. The nurse, who discharged the patient in the photographs, and the patient's granddaughter, who drove the patient home, were interviewed. Both persons stated they did not notice any bruises on her face or lips at the time of discharge. The patient had been very combative with cares in the hospital. Bruises were documented on other parts of her body from these incidents. The patient was refusing food and fluids prior to her discharge, which can have unusual effects on the skin. No evidence of abuse was found.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: A patient lost weight due to not being assisted with meals. The patient also became dehydrated.

Findings: Eighteen clinical records were reviewed. One patient's record documented an 83 year female that was admitted on 2/13/07 with diagnosis of vascular dementia with delusions. She was discharged on 2/25/07. According to her discharge summary, dated 2/26/07, the patient "would not take anything orally." The record contained a "Therapy Progress Note," that documented that the Speech Therapist had preformed an evaluation of the patient on 2/14/07. The evaluation stated, that the Speech Therapist had spoke extensively with spouse regarding the patient's eating skills. On 2/17/07 (un-timed), the Speech Therapist saw the patient and documented the following;

"Pt alert + holding on to staff throughout meal. O/A: Dysphagia: pt exhibits lengthy mastication (with) min oral residue (without) swallow. Pt exhibits occasional s/s of pain (with) mastication during meal holding her jaw + grimacing. Effective oral transfer noted (with) pureed diet consistency. St concern that if pt (changed) to pureed, pt will not recognize food + intakes will be further compromised...caregivers instructed to offer pureed items as snacks to maximize intakes." On 2/19/07 (un-timed), the Speech Therapist documented that "pt exhibiting significantly (decreased) alertness...poor intake." On 2/19/07 (un-timed), the Speech Therapist documented "pt exhibiting significantly (decreased) alertness...family had attempted to feed pt a bite of food which she did not masticate." The patient's "Food Intake Record" documented the patient had refused 24 of 39 meals and drank only 2,250 milliliters of fluids during meals over a 13 day period.

On 6/7/07 at 12:29 PM, a visit was made to the dining room to observe the lunch meal. Fifteen patients and two family members were in the dining room for the meal. Lunch consisted of turkey, mashed potatoes with gravy, a vegetable and pudding. Juice, milk, water and coffee were offered to patients along with their meal. Three staff members were present to serve the lunch and assist patients with eating. One staff member was observed to be cutting the turkey into bite size pieces while another staff member served the trays to patients. The third staff member was observed to encourage and assist patients to eat and drink when needed. When all patients had been served, two staff members were observed to encourage fluids and assist with eating. One staff member was observed feeding a patient who needed total assistance with his meal. Staff documented the percentage of the meal each patient ate and the amount of fluid consumed.

On 6/8/07 at 8:30 AM, an unannounced visit was made to the dining room to observe breakfast. Twelve residents were in the dining room for the meal and 5 staff members were there to assist. One table in the dining room had 2 patients who required total

Two staff members were sitting at the table to assist the patients with eating. The remaining 3 staff members encouraged the more independent patients to eat and drink.

A staff member, interviewed on 6/7/07 at 1:30 PM, stated that they circulated through the dining room and encouraged patients to eat and drink. She said they did assist patients who could not independently feed themselves. Further, she stated they frequently offered additional fluid and food to patients.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: An identified patient was left in bed without socks and was frequently cold.

Findings: During an unannounced visit made to the hospital from 6/4/07 through 6/8/07, patients were observed to be dressed appropriately. Patient's who were observed laying in bed had socks on. Additionally, staff were observed assisting patients with their dressing needs if the patient needed assistance.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #7: An identified patient was unable to hear and talk but was able to write. The hospital did not have a plan in place to communicate with the patient.

Findings: Two clinical records were reviewed of patients that had speech and/or hearing impairments. One patient's record documented an 83 year female admitted on 2/13/07 with diagnosis of vascular dementia with delusions. She was discharged on 2/25/07. According to her "Psychosocial Assessment," dated 2/13/07, the patient had had a stroke and suffered "expressive aphasia." On 2/14/07 (un-timed), the patient's physician ordered an consultation and treatment with a speech therapist. The record contained a "Therapy Progress Note" that documented that the Speech Therapist had preformed an evaluation on 2/14/07(un-timed) that stated, " development of communication book to facilitate (increased) effectiveness of communication." Further it documented follow up visits from the Speech Therapist on 2/17/07, 2/19/07 and 2/24/07. On 2/17/07 (un-timed), the Speech Therapist documented that "communication guidelines developed + staff training initiated." The medical record contained a "Communication Guidelines" for staff from the Speech therapist that stated:

"(Name) is very hard of hearing and has poor vision."

"(Name) will occasionally say a word that will make sense."

"Approach (Name) from the front only."

"(Name) will write single words. Sometimes they are related to what is going on. A lot of times the words are names of family members."

"Use gestures and gentle touch to let (Name) know what is going on."

"There is a communication book with simple words. You can try pointing to the word that relates to what you are doing."

"It is important to her to have a paper and pen to write with."

Another patient's admission history and physical, dated 1/04/07, documented the patient was very hard of hearing in both ears. A "Safety Device Evaluation" form, contained in the patient's record, documented that she could not hear and needed a "board" to communicate. The patient's "Plan of Care" also contained documentation that the patient was hard of hearing and required a "communication board" to communicate with.

On 6/7/07 at 3:50 PM, the acting Director of Nursing Services stated they frequently have patients at the hospital who are either hard of hearing or deaf. She stated they work with the family to assess the best was to communicate with the patient. She said they frequently use a "communication board".

Conclusion: Unsubstantiated. Lack of sufficient evidence.
The hospital conferred with families to assess the best ways to communicate with patients, provided speech therapy as needed, and documented in patient's records interventions needed to communicate the patients.

Allegation #8: An identified patient did not receive appropriate medical treatment.

Findings: An unannounced visit was made to the hospital on 6/4/07 through 6/8/07. Eighteen clinical records were reviewed and staff were interviewed. One patient's record documented an 83 year old female who was admitted on 2/13/07 with a diagnosis of vascular dementia with delusions. She was discharged home on 2/25/07. She died on 2/27/07. On 2/13/07 a "Urinalysis Dip Screen" was performed on the patient's urine. The screen showed that the patient's urine contained, blood, urobilinogen, protein and nitrites. The Physicians Assistant's "Follow up Consultation", dated 2/15/07 at 3:46 PM, stated "patient is being seen today in follow up regarding her medical conditions... her UA was obtained two days ago showing positive for blood, urobilinogen, protein, and nitrate. UA culture is still pending." The "Assessment/Plan" section of the consultation stated, "will continue to monitor signs and symptoms. Will follow up with patient in the next three days or prn (as needed) or when lab tests are available." Laboratory results, dated 2/17/07 at 4:11 PM, documented the urine culture grew "Aerococcus Urinae." The results had the Physicians Assistant's initials on them. There was no further documentation in the

On 6/6/07 at 8:10 AM, the patient's attending physician stated, he was unaware of the patient's urine results. He said the Physicians Assistant usually follows the "treatment for patient's that have urinary tract infections." He further stated, that treatment was normally started for a positive urine dipstick and the prescribed antibiotics might be changed when the culture results were available.

On 6/6/07 at 3:30 PM, the Physicians Assistant stated he'd had a patient in the past, at another facility, that also grew out "Aerococcus Urinae". He stated, he had consulted with a physician at that time and was told that this bacteria was usually not treated when it was isolated in the urine. On 6/7/07 at 10:30 AM, the Physicians Assistant stated that he had thought about the patient further and had remembered why he did not treat the positive urinalysis. He said the decision not to tr1eat was made because it was unclear who had the power to make medical decisions for the patient at that time, so he had only ordered a culture. The Physicians Assistant did not consult with the patient's attending physician about the positive UA or culture results and antibiotics were not prescribed.

The hospital's peer review process was reviewed. It was determined no system was in place for the hospital to review the medical care patients received. In addition, the peer review the hospital had conducted was not in accordance with its policy.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited. Deficiencies were cited at 42 CFR Part 482.22 Condition of Participation for Medical Staff.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

GG/mlw

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	C 06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM FOR BOISE	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The following deficiencies were cited during the complaint investigation survey of your hospital. Surveyors conducting the investigation were: Gary Guiles, RN, HFS, Team Leader Rae Jean McPhillips, RN, HFS Patrick Hendrickson, RN, HFS Acronyms used in this report include: Administrative hold = Involuntary hold CEO = Chief Executive Officer CNA = Certified Nursing Assistant DE = Designated Examiner DNS = Director of Nursing Services HR = Heart Rate IM = Intramuscular PA = Physician Assistant POC = Plan of Care POA = Power of Attorney PT = patient R/A = Room Air RN = Registered Nurse SW = Social Worker UA = Urine Analysis UTI = Urinary Tract Infection	A 000	RECEIVED JUL 13 2007 FACILITY STANDARDS	
A 038	482.13 PATIENTS' RIGHTS A hospital must protect and promote the rights of each patient. This CONDITION is not met as evidenced by: Based on staff interview and review of medical records and facility policies, it was determined the hospital failed to protect and promote the rights of 4 of 5 sampled patients (#s 5, 11, 13 and 18), who were placed on involuntary holds. Refer to	A 038	**Refer to A049 for Plan of Correction.** 7/12/07	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE CEO | (X6) DATE 7/12/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	C 06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM FOR BOISE	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 038	Continued From page 1 A49 as it relates to the failure of the facility to ensure that patients or their representatives had the right to make informed health care decisions. The failure of the hospital to develop a system for involuntary holds resulted in patients being held against their will without due process.	A 038		
A 049	482.13(b)(2) INFORMED DECISIONS The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and facility policies, it was determined the hospital failed to ensure that patients or their representatives had the right to make informed health care decisions. This affected the care of 4 of 5 sampled patients (#s 5, 11, 13 and 18), who were placed on administrative holds. The findings include: 1. Idaho Statutes Title 66 Chapter 3, 66-326. DETENTION WITHOUT HEARING states, "(1) No person shall be taken into custody or detained as an alleged emergency patient for observation, diagnosis, evaluation, care or treatment of mental illness unless and until the court has ordered such apprehension and custody under the provisions outlined in section 66-329, Idaho Code; provided, however, that a person may be taken into custody by a peace officer and placed in a facility, or the person may be detained at a hospital at which the person presented or was brought to receive medical or mental health care, if the peace officer or a physician medical staff member of such hospital has reason to believe that the person is gravely disabled due to mental	A 049	**The Hospital has enhanced it's Involuntary hold policy (formally Administrative Hold) that identifies documentation and evaluation procedures for the staff to follow in the event a patient is a danger to self, others or gravely disabled and it is determined that an involuntary hold is necessary. In addition a commitability assessment has been developed to evaluate the patients psychological status and supports the claim of grave disability due to mental illness or imminent danger to self or others. Application will be faxed to the dully authorized court within 24 hours. Social Services, Licensed Nurses (RN, LPN) and the facility physicians have been inserviced on the policy and documentation required for the process. The facilities Director of Social Service will audit patient charts of all involuntary holds to monitor the process to ensure that patient's rights are duly protected. All results will be reported to the facilities Quality Assurance, Medical Staff and Governing board Committee and action plans developed for any issues noted.** 7/12/07	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	C 06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM FOR BOISE	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 049	Continued From page 2 illness or the person's continued liberty poses an imminent danger to that person or others, as evidenced by a threat of substantial physical harm; provided, under no circumstances shall the proposed patient be detained in a nonmedical unit used for the detention of individuals charged with or convicted of penal offenses. For purposes of this section, the term 'peace officer' shall include state probation and parole officers exercising their authority to supervise probationers and parolees. Whenever a person is taken into custody or detained under this section without court order, the evidence supporting the claim of grave disability due to mental illness or imminent danger must be presented to a duly authorized court within twenty-four (24) hours from the time the individual was placed in custody or detained." The section of the law which allows a "physician medical staff member" to detain a person against their will carries with it the responsibility of the hospital to develop and implement a coherent procedure to evaluate and document the psychiatric status of the person whose rights the hospital is limiting. The hospital failed to develop and implement such a procedure. 2. The hospital's "Administrative Hold" policy, dated 11/4/07, stated in its entirety "Purpose: To hold a patient against their will when the Medical Staff believes the patient may be at high risk for injury to self or others or so severely disabled from mental illness that the patient may be unable to care for self to provide food or shelter. PROCEDURE: 1. Prior to initiating administrative hold: a. Patient will be placed on Elopement Precautions with minimal every 15 minute checks round the clock. b. Nurse will ask patient to sign safety contract outlining commitment to continue care. Contract will be reviewed every shift	A 049		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	C 06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM FOR BOISE	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 049	Continued From page 3	A 049		

between patient and charge nurse. 2. In the event the patient announces a plan or intention to leave the hospital AMA (against medical advice) or appears by their behaviors to be planning elopement, physician places patient on Administrative Hold and initiates petition for a DE (Designated Examiner) to confine the patient against their will. 3. If patient persists and threatens physical harm to staff up to and including leaving against advice and succeeds, staff is to call police and inform them of the patient's elopement and initiation of petition." The policy did not state how the hospital should evaluate the patient's psychological status and how the results of that evaluation would be documented. Further, the policy did not state how evidence supporting the claim of grave disability due to mental illness or imminent danger was to be presented to a duly authorized court within 24 hours from the time the individual was detained, as required by the above law.

3. The records of 4 of 5 sampled patients (#s 5, 11, 13 and 18), who were placed on Administrative holds, did not contain documentation of an evaluation demonstrating a need to place the patient on an involuntary hold. Also, the records for Patients #5, 13, and 18 did not contain documentation that evidence was presented to a court supporting the decision to hold the patient against his/her will. Examples include:

*Patient #5 was an 83 year old female who was admitted on 2/13/07 with a diagnosis of vascular dementia with delusions. She was discharged on 2/25/07. A telephone order, on 2/23/07 (no time documented), placed the patient on an administrative hold. No note by the physician was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	C 06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM FOR BOISE	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 049	Continued From page 4	A 049		

documented at the time the hold was ordered. A progress note from the patient's physician, dated 2/24/07 (the following day), documented "The family wanted to take her home yesterday but nobody had power of attorney or guardianship. She was going to be with her aging husband who is very frail and bipolar son. I didn't feel that was a good situation for her or safe anyway. There were issues prior to coming into the hospital. So I put her on a hold at this time to get that sorted out. There is apparently a daughter we may be able to identify as a potential guardian. Will have to wait and see how that shakes out but I didn't feel she could go home safely anyway based on the situation it looked like she was going into." The form "Application for Commitment", was filled out but not signed, dated, notarized, or filed with the courts. The Application for Commitment stated the purpose for the hold was because "Pt grabbing @ staff and residents refused to let go moaning out loud. Trying to bite RN. Biting staff hair and clothing." The record did not contain documentation of an evaluation demonstrating a need to place the patient on an involuntary hold or support that the patient was gravely disabled or an imminent danger to self or others as required by state law. Also, the record did not state the patient was going to leave AMA or elope, as stated in the hospital's policy. An order to drop the hold was written on 2/25/07 at 12:45 PM. Again, there was no accompanying physician note explaining why the hold was dropped.

On 6/6/07 at 8:10 AM, the patient's attending physician was interviewed. He stated, the family of Patient # 5 came to the hospital and wanted to take her home. He said he was concerned about the possibility of neglect due to the husband being not in the best of health and the son having a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	C 06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM FOR BOISE	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 049	Continued From page 5	A 049		

psychiatric illness and the family not making good decisions. He said he placed the patient on administrative hold to "sort all of this out." He said the patient's granddaughter was involved with this decision and had agreed to the hold process. (The granddaughter disputed this when she was interviewed on 6/7/07 at 1:10 PM.) He said he dropped the hold on 2/25/07 due to the granddaughter and hospice's involvement. He said he felt comfortable to discharge the patient at that time. He said, however, that he did not know what specific services the hospice was going to provide. He said putting the patient on a hold bought the hospital time to get the granddaughter and hospice involved in the patient's care.

On 6/6/06 at 1:30 PM, the SW stated the reason the patient was placed on a hold was because there was no plan to care for her at home. She said, however, that the discharge plan was for the patient to return home all along. The facility failed to ensure Patient #5 was detained for an appropriate cause.

Patient #11 was a 76 year old female who was admitted on 3/23/07 with a diagnosis of major depression. An involuntary hold was ordered by the patient's attending physician on 3/24/07. The patient's record contained an "Application For Commitment" dated, signed and notarized on 3/26/07. The application form stated the "applicant believes the proposed patient (#11) is mentally ill and is likely to injure self or others or is gravely disabled based on the following information and personal observations of the proposed patient's acts and behavior:" Handwritten on the form, it stated "Depressed, anxious, tearful at times, isolating in her room at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	C 06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM FOR BOISE	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 049	Continued From page 6 times. Pt stating she wants to go home to take care of her animals." The application did not state why the physician felt she was a danger to herself or gravely disabled. The record did not contain documentation of an evaluation demonstrating a need to place the patient on an involuntary hold. In spite of this, on 3/26/07, a "Letter of Authority To Assume Mental Hold" from the County Prosecutor was faxed to the hospital. The patient was discharged from the hospital on 3/29/07. There was no documentation in the record or in Department of Health and Welfare records that the patient had been seen by a Designated Examiner. There was no documentation that the patient was legally released by the court prior to discharge. *Patient #18 was a 73 year old female admitted to the hospital on 5/18/07 with diagnoses of psychotic disorder and rule out bipolar disorder. She was currently a patient as of 6/6/07. A physician's order, on 5/18/07 at 5:40 PM, called for the patient to be placed on administrative hold. A nursing note, at 6 PM on 5/18/07, stated "Pt arrived (with) son and no belongings, Other son to bring meds and clothes later. Pt already eaten supper and told she was just coming in to use the restroom. Pt quickly agitated when realized she was here and son had left. Able to deescalate once (name) started talking to her...(as they were from the same place)." The next nursing note stated "Pt asked to talk with son. I called son and asked if he would talk 'with' her. Pt was adamant she didn't need to be or want to be here. She told son that she was disowning all of them." The patient was described as delusional and thought she had won 20 million dollars in the lottery. She was not described as being unable to make decisions or was a danger to herself or gravely	A 049		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	C 06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM FOR BOISE	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 049	Continued From page 7	A 049		

disabled. No physician's note for 5/18/07 was present in the record. The "Nursing Admission Assessment", dated 5/18/07, form stated she was admitted for delusional thinking. She was described as neat and clean in appearance. She was oriented to person, place, and time. The assessment said she was not hallucinating and was not suicidal or a threat to others. No court papers were present in the record. An order, dated 5/21/07, stated to drop the administrative hold. It said the patient had a durable power of attorney for health care.

The RN on duty when Patient #18 was admitted, was interviewed on 6/6/07 at 2:30 PM. She stated the patient was placed on a hold because staff did not think she had a durable power of attorney. She stated she had not assessed the patient's ability to make decisions regarding her care before the administrative hold was initiated. The social worker for Patient #18 was interviewed on 6/6/07 at 4:20 PM. He stated the patient did not have an assessment of the need to be placed on an administrative hold in her record. He also said the legal paper work placing the patient on the hold was not present in the record. He said he could not tell why Patient #18 had been placed on a hold. Patient #18's physician was interviewed on 6/8/07 at 9:15 AM. He stated he had seen the patient on 5/18/07 but had failed to document the encounter. There was no evidence that Patient #18 was unable to make decisions regarding her treatment at the hospital and needed to be held against her will.

*Patient #13 was a 73 year old female admitted to the hospital on 3/13/07 with a diagnosis of dementia. A nursing note at 5:45 PM on 3/13/07 stated "Pt. arrived alert & awake. Ambulating self.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	C 06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM FOR BOISE	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 049	Continued From page 8 Dtrs accompanied. Pt taken down to DR for dinner" At 10:10 PM that evening, the nurse documented "Pt. very angry about being in facility. Pt refused meds , refuses to go to bed & is fully dressed sitting on couch by nurses station waiting for family to pick her up. Pt. withdrawn, some confusion noted." She apparently remained awake all night waiting to leave. A verbal order for the patient to be placed on administrative hold was documented on 3/14/07 at 10:25 AM. The "Initial Psychiatric Evaluation", also dated 3/14/07, stated she was confused but did not document that she had been placed on a hold or the reason why. No other physician note documenting the hold was present in the record. A nursing note documenting the hold was not present in the record. The social worker's note, dated 3/14/07 at 3:49 PM, stated "Patient was placed on an administrative hold due to her repeatedly requesting to leave. Patient's daughters...are working on guardianship. They were going to meet with their attorney this date at 3:00 PM...Administrative paper work was notarized and faxed to the Ada County prosecuting attorney office." The Social Worker, interviewed on 6/6/07 at 1:30 PM, stated the hold was dropped after the daughter obtained guardianship. This was not documented in the record. No record of the legal disposition of the case was documented. The patient's physician reviewed the record on 6/8/07 at 9:15 AM. He stated the circumstances surrounding the hold and an evaluation of the need for the hold were not documented in the record.	A 049		
A 181	482.22 MEDICAL STAFF The hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality	A 181		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	C 06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM FOR BOISE	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 181	Continued From page 9 of care provided to patients by the hospital. This CONDITION is not met as evidenced by: Based on staff interview and review of medical records and facility policies, it was determined the hospital failed to maintain responsibility for the quality of care provided to 4 of 7 sampled patients (#s 1, 2, 5, and 15). Refer to A49 as it relates to the failure of the facility to ensure that medical staff were accountable for the quality of the medical care provided to the patients. The failure of the hospital to maintain responsibility for the quality of medical care resulted in the delay of treatment for patients and a lack of direction to patient care staff.	A 181	**Refer to A049 for Plan of Correction** 7/12/07	
A 185	482.22(b) MED STAFF ACCOUNTABILITY The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to the patients. The medical staff must be organized in a manner approved by the governing body. If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy. The responsibility for organization and conduct of the medical staff must be assigned only to an individual doctor of medicine or osteopathy or, when permitted by State law of the State in which the hospital is located, a doctor of dental surgery or dental medicine.	A 185	**The Hospital has developed a comfort care policy that will direct the staff on how to care for these patients. This policy is flexible enough that patients and/or families through the care plan process can provide input into what areas they would like treated or not. The facilities Licensed Nurses (RN, LPN) have been inserviced on the policy and documentation required for the successful Implementation of this policy. The facilities DNS or designee will audit patient charts of all comfort care patients to monitor the process and care plans any concerns will be addressed immediately. Medical staff is and continues to be accountable for the medical care provided to the patients via the peer review process. All results will be reported to the facilities Quality Assurance committee and action plans developed for any issues noted.** 7/12/07	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	C 06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM FOR BOISE	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 185	Continued From page 10 This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and facility policies, it was determined the hospital failed to ensure the medical staff was accountable for the quality of the medical care provided to the patients. This affected the care of 4 of 7 sampled patients (#s 1, 2, 5, and 15), whose conditions were terminal. In addition, the hospital failed to ensure that 1 of 3 patients, with an identified urinary tract infection, was treated. Finally, the hospital failed to ensure the medical treatment provided to patients was evaluated. The findings include: 1. Four of seven sampled patients (#s 1, 2, 5, and 15) had orders for "comfort measures". However, the hospital had not provided direction to staff as to how to care for these patients. Examples include: * The Acting DNS, interviewed on 6/5/07 at 10:50 AM, stated the hospital had no policy which defined comfort measures and had not provided direction to staff as to how to care for these patients. * Patient #2 was an 89 year old male admitted to the hospital with diagnoses of dementia and depression as well as post cerebrovascular accident, atrioventricular block, and gastro-esophageal reflux disease with a history of bleeding ulcer. He was admitted on 4/30/07 and he died at the hospital on 5/15/07. According to physician progress notes, his medical condition gradually declined and on 5/8/07, the attending physician ordered "comfort measures". The physician progress note on 5/8/07 did not state the rationale for this decision. Subsequent progress notes also did not explain the order.	A 185		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	C 06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM FOR BOISE	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 185	Continued From page 11 Treatment team notes for 5/8/07 did not document the decision to place the patient on comfort measures. An un-timed "Condition Change Form" written by a nurse on 5/8/07, stated "Family requested pt be placed on comfort measures." On 5/14/07 at 1:30 PM, the nurse documented the patient was up in the wheel chair and able to feed himself. The nursing note at 10 PM stated "early in shift, res combative & resistive (with) cares & sustained rt elbow 1-1.5 cm skin tear. Cleansed & dressing & steri on. End of shift, gurgling resps (HOB up) O2 sat R/A 70% & O2 on at 2-3 (liters) per comfort care." The patient died at 12:15 AM on 5/15/07. No documentation was present that the physician was notified of the change in the patient's condition. The Acting DNS, interviewed on 6/8/07 at 11 AM, stated the physician should have been notified of the sudden change in the patient's condition. She speculated that the nurse had not called the physician because comfort measures were ordered for the patient. * Patient #1 was a 95 year old male that was admitted to the hospital on 4/13/07 with diagnoses which included dementia. According to physician progress notes, his medical condition gradually declined and, on 4/21/07, the attending physician ordered "comfort measures". The patient's record did not contain documented interventions to guide staff in the provision of comfort care. The patient died at the hospital on 4/30/07. * Patient #15 was a 63 year old male who was admitted to the hospital on 2/1/07 with diagnoses which included Alzheimer's dementia with psychotic features and combative behaviors. According to physician progress notes, his	A 185		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	C 06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM FOR BOISE	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 185	Continued From page 12	A 185		

medical condition gradually declined and on 2/6/07, the attending physician ordered "comfort measures". The patient's record did not contain documented interventions to guide staff in the provision of comfort care. The patient died at the hospital on 2/17/07.

* Patient #5 was an 83 year old female admitted to the hospital on 2/13/07 with a diagnosis of vascular dementia with delusions. The patient was discharged from the hospital on 2/25/07. Social Worker progress notes, dated 2/21/07, documented that, during a treatment team meeting on 2/20/07, comfort measures were discussed with the family and subsequently ordered by the physician. The patient's record did not contain documented interventions to guide staff in the provision of comfort care.

The Medical Director was interviewed on 6/7/07 at 8:10 AM. He stated "comfort measures" did not have an official meaning and there was not policy defining what it meant. He said it was a "red flag" for staff to alert them that the patient's medical illnesses were not going to be treated aggressively. He reviewed Patient #2's record and stated the nurse should have called him when the patient's condition changed to seek further direction. The Medical Director also stated he did not always write a note when placing a patient on comfort measures but thought the nurse did. He said the nurse had the discretion to not administer oxygen to a patient with low oxygen saturation levels if the patient had comfort measures ordered. It was not clear how the nurse would know this. The acting DNS, interviewed on 6/8/07 at 10:15 AM, stated Patient #2's nurse probably did not call the physician when the patient's condition changed because the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	C 06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM FOR BOISE	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 185	Continued From page 13 patient had orders for "comfort measures". She said there was no policy which defined comfort measures and these were left up to the individual nurse. 2. Three sampled patients had documented evidence of a UTI. The hospital failed to ensure that 1 of these patients (#5) was treated or that a rationale for not treating her was documented. The physician was not aware of the patient's UTI. Patient #5 was a 83 year old female who was admitted on 2/13/07 with a diagnosis of vascular dementia with delusions. She was discharged home on 2/25/07. She died on 2/27/07. On 2/13/07 a "Urinalysis Dip Screen," was performed on the patient's urine. The screen showed that the patient's urine contained, blood, urobilinogen, protein and nitrites. The PA's "Follow up Consultation", dated 2/15/07 at 3:46 PM, stated, "Patient is being seen today in follow up regarding her medical conditions... her UA was obtained two days ago showing positive for blood, urobilinogen, protein, and nitrate. UA culture is still pending." The "Assessment/Plan" section of the consultation stated, "will continue to monitor signs and symptoms. Will follow up with patient in the next three days or prn or when lab tests are available." Laboratory results, dated 2/17/07 at 4:11 PM, documented the urine culture grew "Aerococcus Urinae." The results had the PA's initials on them. There was no further documentation in the patient's record about the positive urine results or possible treatment. On 6/6/07 at 8:10 AM, the patient's attending physician stated he was unaware of the patient's urine results. He said the PA usually follows the "treatment for patient's that have UTI's." He	A 185	**DNS or designee in conjunction with designated medical Staff will concurrently review clinical information to assure treatment is addressed appropriately and timely for identified infections. Variances will be reported to the Quality Assurance and Medical Executive Committees.** **7/12/07**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	C 06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM FOR BOISE	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 185	Continued From page 14 further stated, that treatment was normally started for a positive urine dipstick and the prescribed antibiotics might be changed when the culture results were available. On 6/6/07 at 3:30 PM, the PA stated he'd had a patient in the past, at another facility, that also grew out "Aerococcus Urinae". He stated he had consulted with a physician at that time and was told that this bacteria was usually not treated when it was isolated in the urine. On 6/7/07 at 10:30 AM, the PA stated that he had thought about the patient further and had remembered why he did not treat the positive UA. He said the decision not to treat was made because it was unclear who had the power to make medical decisions for the patient at that time, so he had only ordered a culture. The PA did not consult with the patient's attending physician about the positive UA or culture results and antibiotics were not prescribed. Also, the PA did not seek to clarify who had the power to make medical decisions in order to determine if the UTI should be treated. 3. The hospital had not developed and implemented a system to review the medical care provided to patients. The hospital's mission was to care for elderly patients with psychiatric and behavioral illnesses. Patients treated at the hospital were frequently in their 80s or 90s and had multiple medical diagnoses. For example, Patient #2 was a typical patient. He was 89 years old and had diagnoses of post cerebrovascular accident, atrioventricular block, and gastro-esophageal reflux disease with a history of bleeding ulcer in addition to diagnoses of dementia and depression. The hospital had specific physicians and mid-level providers who	A 185		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	C 06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM FOR BOISE	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 185	Continued From page 15 treated medical conditions in addition to psychiatrists who treated psychiatric conditions. The hospital had a peer review process in place to evaluate the care of psychiatric illnesses. The hospital did not have a process to evaluate the medical care of patients. The policy "PREPARATION FOR PEER REVIEW", dated 10/21/04, stated four medical records per physician per quarter would be reviewed. The Director of Health Information, interviewed 6/6/07 at 11 AM, stated 3 records per physician per quarter were reviewed. A list of cases sent for review documented 3 records per physician were sent. The hospital was behind on the reviews. Only nine records per physician had been peer reviewed since 1/1/06. The Director confirmed this. She said she chose the cases for review. She stated these cases were selected at random. She said cases for review were not selected based on poor outcomes or other specific criteria. The physician who conducted all of the peer review for the facility, since January 1, 2006, was a psychiatrist. The form "PHYSICIAN PEER REVIEW-PSYCHIATRY", dated 8/10/04, was used for all peer review. The only question on the form that addressed the treatment of patients' medical illnesses was "3. Were identified medical problems, including lab results, recognized and acknowledged by the attending physician?" During the exit interview, on 6/8/07 at 1:30 PM, the CEO stated there was no peer review process specific to evaluating the treatment of patients' medical illnesses. A letter, dated 4/25/07, from the hospital to a family member of Patient #5, stated the family	A 185	**The facilities Preparation of Peer review policy has been updated to include a medical peer review. The facility will have 4 charts Per quarter per physician including but not limited to medical review and unexpected clinical outcomes, death and family grievances. Results of the peer review will be presented to the Hospitals Medical Executive Committee and the Governing Board.** 7/12/07	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	C 06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM FOR BOISE	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 185	Continued From page 16 member had questioned the medical care of the patient. The letter stated the CEO had investigated the care the patient received. During an interview, on 6/8/07 at 1:30 PM, the CEO stated a physician peer had not reviewed the case in order to determine whether or not the care was appropriate. He said he had only talked with the patient's attending physician regarding the appropriateness of the treatment provided to Patient #5. He said the hospital had no formal method to evaluate care in response to complaints or poor outcomes.	A 185		
A 204	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on review of clinical records, hospital policies and staff interview, it was determined the hospital failed to ensure a registered nurse supervised and evaluated the nursing care for 2 of 6 patients (#s 2 and 14), whose records were reviewed, that had died in the hospital. Nursing staff did not properly assess, document or call patient's physicians of acute medical changes. The findings include: The hospital's "Chest Pain-Angina" policy, dated 11/4/2004, documented that any patient reporting chest pain would be fully assessed by the RN on duty. This assessment was to include: a set of vital signs, noting the patient's skin temperature, color and degree of moisture, obtaining a complete description of the patient's pain and assessing other possible causes of the pain. The RN would then notify the physician of the	A 204	**All Licensed Nursing Staff have been in-serviced on the assessment and documentation of patients who are experiencing acute medical changes of conditions and notification to the attending physician when changes occur, including the facilities "Chest Pain-Angina" policy and the comfort care policy. Change of conditions will be reviewed on a daily basis through internal facility processes. The DNS or designee will audit charts of patients with acute medical changes of condition and look to see if proper assessments, documentation and physician notification occurred. Results will be presented to the facilities Quality Assurance committee and action steps taken for any issues noted.** **7/12/07**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	C 06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM FOR BOISE	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 204	Continued From page 17 assessment findings for follow up instructions. If the patient's condition began to deteriorate, if pain persisted or vital signs become unstable, the nurse would then call 911 and have patient transferred to the nearest emergency room. This policy had not been followed. Examples include: * Patient #14 was a 88 year old male who was admitted on 2/23/07 with diagnosis of Alzheimer's Disease with aggressive behaviors. He died at the hospital on 3/1/07. A physician's progress note, dated 3/1/07 not timed, stated the "patient was confused but awake and alert." It further stated the patient was "going down hill physically" due to "not eating or drinking." Patient #14's nursing notes, dated 3/1/07, documented the following: 12:35 PM. "Pt confused, (up) in w/c (with one) assist. Pt (refused) meds &food & fluids. Staff encouraged pt to stay (up) today d/t poor sleep (at night)." 1:15 PM. "(Short of breath.) SPO2 88 - O2 put back on - heart rate very irreg. Pt now in bed (with) head elevated 90(degrees)." 9:25 PM. "Pt sitting in bed stiff and (not) moving. Says his chest hurts. HR irregular. Mouth breathing. Visible anxious." 10:40 PM. "No pulse, (no) respirations." The patient's medical record contained no documented evidence from the nurse that she had obtain vital signs or noted the patient's skin temperature, moisture or color. There was no documented evidence that the nurse had	A 204		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	C 06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM FOR BOISE	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 204	Continued From page 18 obtained a description of the pain or other possible causes of pain. Lastly, there was no documented evidence that the nurse had called the patient's physician to report the sudden change in his condition. The nurse who worked at the time the patient had complained of chest pain and died was no longer at the hospital and was not available for interview. The acting DNS was interviewed on 6/8/07 at 2:15 PM. She confirmed there was no documentation to indicate the physician had been notified of the change of condition or that an accurate assessment was done. The nursing staff did not properly assess, document or call patient's physician to notify him of the patient's acute medical change. * Patient #2 was an 89 year old male admitted to the hospital with diagnoses of dementia and depression as well as post cerebrovascular accident, atrioventricular block, and gastro-esophageal reflux disease with a history of bleeding ulcer. He died at the hospital on 5/15/07. According to physician progress notes, his medical condition gradually declined and on 5/8/07, the attending physician ordered "comfort measures". On 5/14/07 at 1:30 PM, the nurse documented the patient was up in the wheel chair and able to feed himself. The nursing note at 10 PM stated "early in shift, res combative & resistive (with) cares & sustained rt elbow 1-1.5 cm skin tear. Cleansed & dressing & steri on. End of shift, gurgling resps (HOB up) O2 sat R/A 70% & O2 on at 2-3 (liters) per comfort care." The patient died at 12:15 AM on 5/15/07. No documentation was present that a complete nursing assessment was performed or that the physician was notified of the change in the	A 204		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	C 06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM FOR BOISE	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 204	Continued From page 19 patient's condition. The Acting DNS, interviewed on 6/8/07 at 11 AM, stated the physician should have been notified of the sudden change in the patient's condition. The hospital failed to ensure a registered nurse supervised and evaluated the nursing care in the hospital. Nursing staff did not properly assess, document or call patient's physicians of acute medical changes.	A 204		
A 205	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the hospital failed to ensure staff developed nursing care plans for 4 of 4 patients (#'s 1, 2, 5 and 15) whose physician's ordered comfort care measures. Further, staff failed to develop a nursing care plan for 1 of 2 patients (#15) whose records were reviewed for intrusive behaviors. These failures resulted in the potential for unmet patient needs. The findings include: 1. Nursing staff failed to develop nursing care plans that guided staff in providing comfort care to terminal patients. * Patient #1 was a 95 year old male that was admitted to the hospital on 4/13/07 with diagnoses which included dementia. The patient died at the hospital on 4/30/07. According to physician progress notes, his medical condition gradually declined and on 4/21/07, the attending	A 205	**The Hospital has and continues to have nursing Care plans for each patient. The Hospital has developed a comfort care policy that will direct the staff on how to care for these patients placed on comfort care. This policy will allow individualization for patients and families through the care plan process In addition nursing staff will care plan interventions for patients who have intrusive/wandering behaviors. All Licensed Staff (RN, LPN) have been in serviced on the comfort care policy and the care planning process for interventions for patients with intrusive behaviors. The Director of Nursing or designee will audit patient charts for comfort care and behaviors to assure proper interventions/care plans are in place. Results will be presented to the facilities Quality Assurance committee and action steps taken for and issues noted.** 7/12/07	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	C 06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM FOR BOISE	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 205	Continued From page 20 physician ordered "comfort measures". The patient's POC did not provide interventions or direct staff on the provision of comfort measures. * Patient #2 was an 89 year old male admitted to the hospital with diagnoses of dementia and depression as well as post cerebrovascular accident, atrioventricular block, and gastro-esophageal reflux disease with a history of bleeding ulcer. He died at the hospital on 5/15/07. According to physician progress notes, his medical condition gradually declined and on 5/8/07, the attending physician ordered "comfort measures". The patient's POC was not changed to reflect this order or what actions nurses should take. This was confirmed by the acting DNS on 6/8/07 at 11 AM. * Patient #5 was an 83 year old female admitted to the hospital on 2/13/07 with a diagnosis of vascular dementia with delusions. The patient was discharged from the hospital on 2/25/07. Social Worker progress notes, dated 2/21/07, documented that during a treatment team meeting, on 2/20/07, comfort measures were discussed with the family. These were subsequently ordered by the physician. The patient's POC did not contain documented interventions to guide staff in the provision of comfort measures. * Patient #15 was a 63 year old male that was admitted to the hospital on 2/1/07 with diagnoses which included Alzheimer's dementia with psychotic features and combative behaviors. The patient died at the hospital on 2/17/07. According to physician progress notes, his medical condition gradually declined and on 2/6/07, the attending physician ordered "comfort measures". The	A 205		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	C 06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM FOR BOISE	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 205	Continued From page 21 patient's POC did not provide interventions or direct staff on the provision of comfort measures. On 6/6/07 at 2:34 PM, a charge RN stated that comfort care consisted of whatever a family wanted. She stated the hospital did not have policies and procedures to guide staff on providing comfort measures, that it was up to each nurse to decide what cares were needed. On 6/7/07 at 3:50 PM, the acting DNS stated the hospital did not have policies and procedures to guide staff in providing comfort care to terminal patients. Additionally, she confirmed that none of the patients, whose records were reviewed, contain POCs that incorporate patient/family wishes or provide interventions to guide staff in the provision of comfort measures. 2. Nursing staff failed to develop a POC to guide staff in implementing interventions to prevent Patient #15 from wandering into patients' rooms or other inappropriate behaviors. Patient #15 was a 63 year old male that was admitted to the hospital on 2/1/07 with diagnoses which included Alzheimer's dementia with psychotic features and combative behaviors. The patient's medical record documented the following behaviors: 2/2/07 at 6 PM - "intrusive going into other patient's rooms" 2/3/07 at 3 PM- "going into other patient's rooms, inappropriate elimination" 2/5/07 at 9:45 PM - "intrusive... inappropriately voiding in trash cans" 2/7/07 untimed - "intrusive to pt's rooms, getting in pt's beds empty or not"	A 205		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	C 06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM FOR BOISE	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 205	Continued From page 22 2/9/07 at 9 AM - "in & out of pt rooms" The patient's POC did not document or direct staff how to prevent these behaviors. The acting DNS confirmed on 6/7/07 at 3:50 PM, that the POC did not address the patient's intrusive or inappropriate behaviors.	A 205		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
B 000	16.03.14 Initial Comments The following deficiencies were cited during the complaint investigation survey of your hospital for compliance with state licensure. Surveyors conducting the investigation were: Gary Guiles, RN, HFS, Team Leader Rae Jean McPhillips, RN, HFS Patrick Hendrickson, RN, HFS Acronyms used in this report include: Administrative hold = Involuntary hold CEO = Chief Executive Officer CNA = Certified Nursing Assistant DE = Designated Examiner DNS = Director of Nursing Services HR = Heart Rate IM = Intramuscular PA = Physician Assistant POC = Plan of Care POA = Power of Attorney PT = patient R/A = Room Air RN = Registered Nurse SW = Social Worker UA = Urine Analysis UTI = Urinary Tract Infection	B 000	RECEIVED JUL 13 2007 FACILITY STANDARDS	
BB144	16.03.14.250.01 Medical Staff Qualifications and Privileges 250. MEDICAL STAFF. The hospital shall have an active medical staff organized under bylaws approved by the governing body and responsible to the governing body for the quality of all medical care provided the patients, and for the professional practices and ethical conduct of the members. (10-14-88)	BB144	**Refer to Plan of Correction A185**	7/12/07

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 7/12/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB144	Continued From page 1 01. Medical Staff Qualifications and Privileges. All medical staff members shall be qualified legally and professionally, for the privileges which they are granted. (10-14-88) a. Privileges shall be granted only on the basis of individual training, competence, and experience. (10-14-88) b. The medical staff, with governing body approval, shall develop and implement a written procedure for determining qualifications for medical staff appointment, and for determining privileges. (10-14-88) c. The governing body shall approve medical staff privileges within the limits of the hospital's capabilities for providing qualified support staff and equipment in specialized areas. (10-14-88) This Rule is not met as evidenced by: Based on staff interview and review of medical records and facility policies, it was determined the hospital failed to ensure the medical staff was accountable for the quality of the medical care provided to the patients. This affected the care of 4 of 7 sampled patients (#s 1, 2, 5, and 15), whose conditions were terminal. In addition, the hospital failed to ensure that 1 of 3 patients, with an identified urinary tract infection, was treated. Finally, the hospital failed to ensure the medical treatment provided to patients was evaluated. The findings include: 1. Four of seven sampled patients (#s 1, 2, 5, and 15) had orders for "comfort measures". However, the hospital had not provided direction to staff as to how to care for these patients. Examples include:	BB144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB144	Continued From page 2 * The Acting DNS, interviewed on 6/5/07 at 10:50 AM, stated the hospital had no policy which defined comfort measures and had not provided direction to staff as to how to care for these patients. * Patient #2 was an 89 year old male admitted to the hospital with diagnoses of dementia and depression as well as post cerebrovascular accident, atrioventricular block, and gastro-esophageal reflux disease with a history of bleeding ulcer. He was admitted on 4/30/07 and he died at the hospital on 5/15/07. According to physician progress notes, his medical condition gradually declined and on 5/8/07, the attending physician ordered "comfort measures". The physician progress note on 5/8/07 did not state the rationale for this decision. Subsequent progress notes also did not explain the order. Treatment team notes for 5/8/07 did not document the decision to place the patient on comfort measures. An un-timed "Condition Change Form" written by a nurse on 5/8/07, stated "Family requested pt be placed on comfort measures." On 5/14/07 at 1:30 PM, the nurse documented the patient was up in the wheel chair and able to feed himself. The nursing note at 10 PM stated "early in shift, res combative & resistive (with) cares & sustained rt elbow 1-1.5 cm skin tear. Cleansed & dressing & steri on. End of shift, gurgling resps (HOB up) O2 sat R/A 70% & O2 on at 2-3 (liters) per comfort care." The patient died at 12:15 AM on 5/15/07. No documentation was present that the physician was notified of the change in the patient's condition. The Acting DNS, interviewed on 6/8/07 at 11 AM, stated the physician should have been notified of the sudden change in the patient's condition. She speculated that the nurse had not called the physician because comfort measures	BB144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB144	Continued From page 3 were ordered for the patient. * Patient #1 was a 95 year old male that was admitted to the hospital on 4/13/07 with diagnoses which included dementia. According to physician progress notes, his medical condition gradually declined and, on 4/21/07, the attending physician ordered "comfort measures". The patient's record did not contain documented interventions to guide staff in the provision of comfort care. The patient died at the hospital on 4/30/07. * Patient #15 was a 63 year old male who was admitted to the hospital on 2/1/07 with diagnoses which included Alzheimer's dementia with psychotic features and combative behaviors. According to physician progress notes, his medical condition gradually declined and on 2/6/07, the attending physician ordered "comfort measures". The patient's record did not contain documented interventions to guide staff in the provision of comfort care. The patient died at the hospital on 2/17/07. * Patient #5 was an 83 year old female admitted to the hospital on 2/13/07 with a diagnosis of vascular dementia with delusions. The patient was discharged from the hospital on 2/25/07. Social Worker progress notes, dated 2/21/07, documented that, during a treatment team meeting on 2/20/07, comfort measures were discussed with the family and subsequently ordered by the physician. The patient's record did not contain documented interventions to guide staff in the provision of comfort care. The Medical Director was interviewed on 6/7/07 at 8:10 AM. He stated "comfort measures" did not have an official meaning and there was not	BB144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB144	Continued From page 4 policy defining what it meant. He said it was a "red flag" for staff to alert them that the patient's medical illnesses were not going to be treated aggressively. He reviewed Patient #2's record and stated the nurse should have called him when the patient's condition changed to seek further direction. The Medical Director also stated he did not always write a note when placing a patient on comfort measures but thought the nurse did. He said the nurse had the discretion to not administer oxygen to a patient with low oxygen saturation levels if the patient had comfort measures ordered. It was not clear how the nurse would know this. The acting DNS, interviewed on 6/8/07 at 10:15 AM, stated Patient #2's nurse probably did not call the physician when the patient's condition changed because the patient had orders for "comfort measures". She said there was no policy which defined comfort measures and these were left up to the individual nurse. 2. Three sampled patients had documented evidence of a UTI. The hospital failed to ensure that 1 of these patients (#5) was treated or that a rationale for not treating her was documented. The physician was not aware of the patient's UTI. Patient #5 was a 83 year old female who was admitted on 2/13/07 with a diagnosis of vascular dementia with delusions. She was discharged home on 2/25/07. She died on 2/27/07. On 2/13/07 a "Urinalysis Dip Screen," was performed on the patient's urine. The screen showed that the patient's urine contained, blood, urobilinogen, protein and nitrites. The PA's "Follow up Consultation", dated 2/15/07 at 3:46 PM, stated, "Patient is being seen today in follow up regarding her medical conditions... her UA was obtained two days ago showing positive for blood,	BB144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB144	Continued From page 5 urobilinogen, protein, and nitrate. UA culture is still pending." The "Assessment/Plan" section of the consultation stated, "will continue to monitor signs and symptoms. Will follow up with patient in the next three days or prn or when lab tests are available." Laboratory results, dated 2/17/07 at 4:11 PM, documented the urine culture grew "Aerococcus Urinae." The results had the PA's initials on them. There was no further documentation in the patient's record about the positive urine results or possible treatment. On 6/6/07 at 8:10 AM, the patient's attending physician stated he was unaware of the patient's urine results. He said the PA usually follows the "treatment for patient's that have UTI's." He further stated, that treatment was normally started for a positive urine dipstick and the prescribed antibiotics might be changed when the culture results were available. On 6/6/07 at 3:30 PM, the PA stated he'd had a patient in the past, at another facility, that also grew out "Aerococcus Urinae". He stated he had consulted with a physician at that time and was told that this bacteria was usually not treated when it was isolated in the urine. On 6/7/07 at 10:30 AM, the PA stated that he had thought about the patient further and had remembered why he did not treat the positive UA. He said the decision not to teat was made because it was unclear who had the power to make medical decisions for the patient at that time, so he had only ordered a culture. The PA did not consult with the patient's attending physician about the positive UA or culture results and antibiotics were not prescribed. Also, the PA did not seek to clarify who had the power to make medical decisions in order to determine if the UTI should be treated.	BB144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB144	Continued From page 6 3. The hospital had not developed and implemented a system to review the medical care provided to patients. The hospital's mission was to care for elderly patients with psychiatric and behavioral illnesses. Patients treated at the hospital were frequently in their 80s or 90s and had multiple medical diagnoses. For example, Patient #2 was a typical patient. He was 89 years old and had diagnoses of post cerebrovascular accident, atrioventricular block, and gastro-esophageal reflux disease with a history of bleeding ulcer in addition to diagnoses of dementia and depression. The hospital had specific physicians and mid-level providers who treated medical conditions in addition to psychiatrists who treated psychiatric conditions. The hospital had a peer review process in place to evaluate the care of psychiatric illnesses. The hospital did not have a process to evaluate the medical care of patients. The policy "PREPARATION FOR PEER REVIEW", dated 10/21/04, stated four medical records per physician per quarter would be reviewed. The Director of Health Information, interviewed 6/6/07 at 11 AM, stated 3 records per physician per quarter were reviewed. A list of cases sent for review documented 3 records per physician were sent. The hospital was behind on the reviews. Only nine records per physician had been peer reviewed since 1/1/06. The Director confirmed this. She said she chose the cases for review. She stated these cases were selected at random. She said cases for review were not selected based on poor outcomes or other specific criteria. The physician who conducted all of the peer review for the facility, since January 1, 2006, was	BB144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB144	Continued From page 7 a psychiatrist. The form "PHYSICIAN PEER REVIEW-PSYCHIATRY", dated 8/10/04, was used for all peer review. The only question on the form that addressed the treatment of patients' medical illnesses was "3. Were identified medical problems, including lab results, recognized and acknowledged by the attending physician?" During the exit interview, on 6/8/07 at 1:30 PM, the CEO stated there was no peer review process specific to evaluating the treatment of patients' medical illnesses. A letter, dated 4/25/07, from the hospital to a family member of Patient #5, stated the family member had questioned the medical care of the patient. The letter stated the CEO had investigated the care the patient received. During an interview, on 6/8/07 at 1:30 PM, the CEO stated a physician peer had not reviewed the case in order to determine whether or not the care was appropriate. He said he had only talked with the patient's attending physician regarding the appropriateness of the treatment provided to Patient #5. He said the hospital had no formal method to evaluate care in response to complaints or poor outcomes.	BB144		
BB175	16.03.14.310.03 Patient Care Plans 03. Patient Care Plans. Individual patient care plans shall be developed, implemented and kept current for each inpatient. Each patient care plan shall include but is not limited to: (10-14-88) a. Nursing care treatments required by the patient; and (10-14-88) b. Medical treatment ordered for the patient; and (10-14-88)	BB175	Refer to Plan of Correction A205	7/12/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB175	Continued From page 8 c. A plan devised to include both short-term and long-term goals; and (10-14-88) d. Patient and family teaching plan both for hospital stay and discharge; and (10-14-88) e. A description of socio-psychological needs of the patient and a plan to meet those needs. (10-14-88) This Rule is not met as evidenced by: Based on medical record review and staff interview, it was determined the hospital failed to ensure staff developed nursing care plans for 4 of 4 patients (#'s 1, 2, 5 and 15) whose physician's ordered comfort care measures. Further, staff failed to develop a nursing care plan for 1 of 2 patients (#15) whose records were reviewed for intrusive behaviors. These failures resulted in the potential for unmet patient needs. The findings include: 1. Nursing staff failed to develop nursing care plans that guided staff in providing comfort care to terminal patients. * Patient #1 was a 95 year old male that was admitted to the hospital on 4/13/07 with diagnoses which included dementia. The patient died at the hospital on 4/30/07. According to physician progress notes, his medical condition gradually declined and on 4/21/07, the attending physician ordered "comfort measures". The patient's POC did not provide interventions or direct staff on the provision of comfort measures. * Patient #2 was an 89 year old male admitted to the hospital with diagnoses of dementia and depression as well as post cerebrovascular accident, atrioventricular block, and	BB175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB175	Continued From page 9 gastro-esophageal reflux disease with a history of bleeding ulcer. He died at the hospital on 5/15/07. According to physician progress notes, his medical condition gradually declined and on 5/8/07, the attending physician ordered "comfort measures". The patient's POC was not changed to reflect this order or what actions nurses should take. This was confirmed by the acting DNS on 6/8/07 at 11 AM. * Patient #5 was an 83 year old female admitted to the hospital on 2/13/07 with a diagnosis of vascular dementia with delusions. The patient was discharged from the hospital on 2/25/07. Social Worker progress notes, dated 2/21/07, documented that during a treatment team meeting, on 2/20/07, comfort measures were discussed with the family. These were subsequently ordered by the physician. The patient's POC did not contain documented interventions to guide staff in the provision of comfort measures. * Patient #15 was a 63 year old male that was admitted to the hospital on 2/1/07 with diagnoses which included Alzheimer's dementia with psychotic features and combative behaviors. The patient died at the hospital on 2/17/07. His medical condition gradually declined and on 2/6/07, the attending physician ordered "comfort measures". The patient's POC did not provide interventions or direct staff on the provision of comfort measures. On 6/6/07 at 2:34 PM, a charge RN stated that comfort care consisted of whatever a family wanted. She stated the hospital did not have policies and procedures to guide staff on providing comfort measures, that it was up to each nurse to decide what cares were needed.	BB175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB175	Continued From page 10 On 6/7/07 at 3:50 PM, the acting DNS stated the hospital did not have policies and procedures to guide staff in providing comfort care to terminal patients. Additionally, she confirmed that none of the patients, whose records were reviewed, contain POCs that incorporate patient/family wishes or provide interventions to guide staff in the provision of comfort measures. 2. Nursing staff failed to develop a POC to guide staff in implementing interventions to prevent Patient #15 from wandering into patients' rooms or other inappropriate behaviors. Patient #15 was a 63 year old male that was admitted to the hospital on 2/1/07 with diagnoses which included Alzheimer's dementia with psychotic features and combative behaviors. The patient's medical record documented the following behaviors: 2/2/07 at 6 PM - "intrusive going into other patient's rooms" 2/3/07 at 3 PM- "going into other patient's rooms, inappropriate elimination" 2/5/07 at 9:45 PM - "intrusive... inappropriately voiding in trash cans" 2/7/07 untimed - "intrusive to pt's rooms, getting in pt's beds empty or not" 2/9/07 at 9 AM - "in & out of pt rooms" The patient's POC did not document or direct staff how to prevent these behaviors. The acting DNS confirmed on 6/7/07 at 3:50 PM, that the POC did not address the patient's intrusive or inappropriate behaviors.	BB175		
BB182	16.03.14.310.10 Staff Assignments	BB182		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB182	Continued From page 11 10. Staff Assignments. Registered nurses shall make assignments for nursing care. (10-14-88) a. In the absence of the Director of Nursing Services, an RN shall be designated to assume the director's duties. (10-14-88) b. There shall be a registered nurse on duty at all times. (10-14-88) c. There shall be twenty-four (24) hour registered nurse coverage in critical care areas in accordance with Subsection 420.02.d. Exception: small hospitals may have an available registered nurse on call to the critical care unit, when there are no patients in the critical care unit. (12-31-91) d. No person will be assigned nursing duties (aides and orderlies included) who has been on duty in the facility during the preceding twelve (12) hours, except in an emergency. (10-14-88) e. There shall be sufficient numbers of nursing personnel in all categories to ensure quality of patient care. (10-14-88) f. Personnel who have a communicable disease, infectious wound or other transmittable conditions and who provide care or services to patients shall be required to implement protective infection control techniques approved by administration; or be required not to work until the infectious stage is corrected; or be reassigned to a work area where contact with others is not expected and likelihood of transmission of infection is absent; or seek other remedy to avoid spreading the employees infection. (10-14-88) g. A registered nurse shall make assignments of nursing care to nursing assistants. (10-14-88)	BB182	Refer to Plan of Correction A204	7/12/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB182	Continued From page 12 h. Private duty nurses shall be currently licensed in Idaho and shall comply with all hospital rules and regulations, and be under the general direction of the appropriate DNS. (10-14-88) i. Private duty nurses shall not be assigned to critical care areas unless properly oriented and fully trained to the policies and procedures of the hospital. (10-14-88) This Rule is not met as evidenced by: Based on review of clinical records, hospital policies and staff interview, it was determined the hospital failed to ensure a registered nurse supervised and evaluated the nursing care for 2 of 6 patients (#s 2 and 14), whose records were reviewed, that had died in the hospital. Nursing staff did not properly assess, document or call patient's physicians of acute medical changes. The findings include: The hospital's "Chest Pain-Angina" policy, dated 11/4/2004, documented that any patient reporting chest pain would be fully assessed by the RN on duty. This assessment was to include: a set of vital signs, noting the patient's skin temperature, color and degree of moisture, obtaining a complete description of the patient's pain and assessing other possible causes of the pain. The RN would then notify the physician of the assessment findings for follow up instructions. If the patient's condition began to deteriorate, if pain persisted or vital signs become unstable, the nurse would then call 911 and have patient transferred to the nearest emergency room. This policy had not been followed. Examples include: * Patient #14 was a 88 year old male who was admitted on 2/23/07 with diagnosis of Alzheimer's	BB182		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB182	Continued From page 13 Disease with aggressive behaviors. He died at the hospital on 3/1/07. A physician's progress note, dated 3/1/07 not timed, stated the "patient was confused but awake and alert." It further stated the patient was "going down hill physically" due to "not eating or drinking." Patient #14's nursing notes, dated 3/1/07, documented the following: 12:35 PM. "Pt confused, (up) in w/c (with one) assist. Pt (refused) meds &food & fluids. Staff encouraged pt to stay (up) today d/t poor sleep (at night)." 1:15 PM. "(Short of breath.) SPO2 88 - O2 put back on - heart rate very irreg. Pt now in bed (with) head elevated 90(degrees)." 9:25 PM. "Pt sitting in bed stiff and (not) moving. Says his chest hurts. HR irregular. Mouth breathing. Visible anxious." 10:40 PM. "No pulse, (no) respirations." The patient's medical record contained no documented evidence from the nurse that she had obtain vital signs or noted the patient's skin temperature, moisture or color. There was no documented evidence that the nurse had obtained a description of the pain or other possible causes of pain. Lastly, there was no documented evidence that the nurse had called the patient's physician to report the sudden change in his condition. The nurse who worked at the time the patient had complained of chest pain and died was no longer at the hospital and was not available for interview. The acting DNS was interviewed on 6/8/07 at	BB182		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134009	A. BUILDING _____ B. WING _____	06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNHEALTH BEHAVIORAL HEALTH SYSTEM	8050 NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB182	Continued From page 14 2:15 PM. She confirmed there was no documentation to indicate the physician had been notified of the change of condition or that an accurate assessment was done. The nursing staff did not properly assess, document or call patient's physician to notify him of the patient's acute medical change. * Patient #2 was an 89 year old male admitted to the hospital with diagnoses of dementia and depression as well as post cerebrovascular accident, atrioventricular block, and gastro-esophageal reflux disease with a history of bleeding ulcer. He died at the hospital on 5/15/07. According to physician progress notes, his medical condition gradually declined and on 5/8/07, the attending physician ordered "comfort measures". On 5/14/07 at 1:30 PM, the nurse documented the patient was up in the wheel chair and able to feed himself. The nursing note at 10 PM stated "early in shift, res combative & resistive (with) cares & sustained rt elbow 1-1.5 cm skin tear. Cleansed & dressing & steri on. End of shift, gurgling resps (HOB up) O2 sat R/A 70% & O2 on at 2-3 (liters) per comfort care." The patient died at 12:15 AM on 5/15/07. No documentation was present that a complete nursing assessment was performed or that the physician was notified of the change in the patient's condition. The Acting DNS, interviewed on 6/8/07 at 11 AM, stated the physician should have been notified of the sudden change in the patient's condition. The hospital failed to ensure a registered nurse supervised and evaluated the nursing care in the hospital. Nursing staff did not properly assess, document or call patient's physicians of acute medical changes.	BB182		